

# **FISCAL NOTE**

## **SB 3127 - HB 2949**

March 24, 1998

**SUMMARY OF BILL:** Enacts the Consumer Health Care Advocacy Act which includes health insurance companies, health maintenance organizations and managed care organizations. Requires health maintenance organizations to offer enrollees a point of service (POS) or preferred provider organization (PPO) option. The premium for such an option is to be fair and reasonable as determined by the Department of Commerce and Insurance. Premiums, copayments and other cost sharing arrangements may not exceed twenty percent of the normal charges and copayments shall not exceed thirty dollars. The bill requires that non-participating providers be reimbursed at the same rate as participating providers under the PPO or POS options.

The bill also establishes network adequacy standards for health maintenance organizations and requires referrals to out of network providers when the HMO has none. Health insurance insurers are required to provide direct access for women enrollees to obstetric/gynecologists as primary care providers. Insurers are required to provide direct access to specialists for enrollees with life threatening, chronic, disabling or degenerative conditions. Insurers are required to provide standing referrals to specialists for enrollees with chronic conditions for a period of twelve months. Requires insurers to provide continuity of care for up to 180 days when a provider is terminated from the plan. The bill requires all insurers to contract with any licensed pharmacist or pharmacy that agrees to the plans terms and conditions.

### **ESTIMATED FISCAL IMPACT:**

**Increase State Expenditures - Exceeds \$100,000,000**

**Increase State Revenues - Exceeds \$1,000,000**

**Increase Local Govt Expenditures - \$6,000,000\***

**Increase Local Govt. Revenues - Exceeds \$1,000,000**

Breakdown of cost:

1. Point of service or preferred provider option.

**Increase State Expenditures - Exceeds \$20,000,000**

**Increase State Revenues - Exceeds \$1,000,000**

**Increase Local Govt. Expenditures - Exceeds \$1,000,000**

**Increase Local Govt. Revenues - Exceeds \$1,000,000**

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Assumes that the bill will require the TennCare program to offer a POS or PPO option since all TennCare managed care organizations are regulated HMOs. Assumes TennCare enrollees will be subject to pay deductibles or co-pays in order to participate in the program.

Assumes premiums charged to TennCare enrollees will remain on a sliding scale, based on income level, and that the POS and PPO option will have to be offered to all TennCare enrollees.

Assumes a significant number of TennCare enrollees will choose either the PPO or the POS option.

Assumes that any HMO contracting with the state or local government to provide health insurance plans would be required to offer a POS or PPO option. Estimate assumes any increased cost to state or local government health care plans would be covered by increasing premiums paid by employees who choose the POS or PPO plan.

## 2. Network Adequacy

### **Minimal**

Estimate assumes the provision of this section of the bill closely parallel the existing requirements of TennCare and are already met by most state and local government health care plans.

## 3. Scope of Services

**Increase State Expenditures - Exceeds \$90,000,000**

**Increase Local Govt Expenditures\* - Exceeds \$5,000,000**

Prevents non-discrimination clauses in provider selection if the provider's service is a covered benefit. Also allows any provider to join a network that meets the requirements of the network. Assumes that the provisions of the bill will result in an estimated increase in capitation rates paid in the TennCare program, an increase in expenditures to the state employee health plan, since this plan utilizes existing networks of health care providers, and increased expenditures to local government health care plans. Self-funded plans could avoid the provisions of the bill if they established their own network of health care providers because of the ERISA statute, however, the cost of establishing and administering the network is estimated to be significant.

This estimate is based on the following:

- An incentive presently exists for health care providers to accept set fee schedules or agree to discounts against usual and customary fees in order to be a part of large health care plans.
- Even though contracts with health care providers may not specifically guarantee a volume of patients, it appears logical on the part of the provider to conclude that such plans bring with them incentives or mandates for plan members to use providers in the plan.
- Allowing an increased number of providers into a plan reduces the likelihood that a provider will receive a significant amount of business as a result of being a member of such plan, removing most of the incentive for that provider to accept set fee schedules or agree to specified discounts against usual and customary fees.
- Allowing an increased number of providers into the plan will result in increased administrative cost to HMOs and health insurance plans.

For informational purposes the Tennessee General Assembly's Special Study Committee, on the Tennessee Patient Advocacy Act of 1997, conducted a study on the impact of any willing provider legislation. According to the consultant's report the estimated impact of implementing any willing provider legislation would be increased expenditures to TennCare of \$97,632,000 and \$9,439,546 to state and local government employee health care plans.

Direct Access

**Increase State Expenditures – Exceeds \$1,000,000 (TennCare)  
Increase Local Govt. Expenditures – Exceeds \$100,000**

Assumes that the provisions requiring direct access to some specialists as primary care providers and requiring standing referrals to specialists in some instances will increase the cost to the TennCare program. The amount of such increase cannot be determined but is estimated to exceed \$1,000,000.

4. Continuity of Care

**Increase State Expenditures – Not Significant  
Increase Local Govt. Expenditures – Not Significant**

Any increased cost of health care benefits to HMOs is not estimated to be significant enough to cause a significant increase in state and local government health care plans. The impact on HMOs is not estimated to be significant enough to cause an increase in capitation rates. The estimate is based

on the short duration of time which is allowed by the bill and the requirement for providers to accept the network rates.

5. Any willing provider provisions for pharmacy.

**Increased State Expenditures - Exceeds \$1,000,000**  
**Increased Local Govt. Expenditures\*. - Exceeds \$100,000**

Estimate assumes an increase in expenditures to MCOs for covered drugs, which will ultimately lead to an increase in capitation rates in the TennCare program. Assumes that contract prices obtained by MCOs will be affected since prospective contractors would reasonably expect a reduction in volume if any pharmacy is allowed to join the network. The amount of such increase cannot be determined but is estimated to be significant.

The bill would not directly impact the state employee health insurance plan or most local government health insurance plans, since federal law (ERISA) exempts self-insured plans. However, some increased cost may accrue to local government health care plans that are not self-funded, and to self-funded plans which use existing MCO networks.

*\*Article II, Section 24 of the Tennessee Constitution provides that: no law of general application shall impose increased expenditure requirements on cities or counties unless the General Assembly shall provide that the state share in the cost.*

**CERTIFICATION:**

This is to duly certify that the information contained herein is true and correct to the best of my knowledge.



James A. Davenport, Executive Director